FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

Botox® Coverage Determination Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type(s) of Coverage Determination Requested:

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

❑ **Quantity Limit**- Request is for an exception to the plan's quantity limit.

Quantity per 90 DAYS requested? _____

Select the diagnosis below:

❑ Blepharospasms associated with dystonia
❑ Cervical dystonia
❑ Chronic anal fissure or anal spasm
❑ Chronic migraine
❑ Focal dystonia or spastic dystonia
❑ Overactive bladder
❑ Severe primary focal hyperhidrosis
❑ Sialorrhea (excessive drooling)
❑ Spasmodic dystonia or laryngeal dystonia
❑ Spasticity of the limbs
❑ Strabismus
❑ Urinary incontinence
❑ Other diagnosis: _____ ICD-10 Code(s): _____

For chronic anal fissure or anal spasm, answer the following:

Have the patient's symptoms been unresponsive to conventional treatments (e.g., steroids, nitroglycerin)? ❑ **Yes** ❑ **No**

For chronic migraine, answer the following:

Does the patient have chronic migraine (at least 15 days per month with headache lasting 4 hours a day or longer)? ❑ **Yes** ❑ **No**

Select if the patient has had an inadequate response or inability to tolerate medications from the following drug classes:

❑ Anticonvulsants
❑ Beta blockers (BB)
❑ Calcium channel blockers (CCB)
❑ Selective serotonin reuptake inhibitors (SSRIs)
❑ Serotonin norepinephrine reuptake inhibitors (SNRIs)
❑ Tricyclic antidepressants (TCAs)

Is the requested medication prescribed by a neurologist? ❑ **Yes** ❑ **No**

For overactive bladder or urinary incontinence, answer the following:

Has the patient had an inadequate response or an inability to tolerate an anticholinergic medication? ❑ **Yes** ❑ **No**

For sialorrhea (excessive drooling), answer the following:

Is the patient's sialorrhea (excessive drooling) due to disabling conditions such as motor neuron disease or Parkinson's disease? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response or inability to tolerate glycopyrrolate or transdermal scopolamine? ❑ **Yes** ❑ **No**

Botox® Coverage Determination Request Form (Page 2 of 2)

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For spasticity of the limbs, answer the following:

Select if the patient's limb spasticity is related to any of the following conditions:

- ❑ Brain injury
- ❑ Cerebral palsy
- ❑ Demyelinating disease of the central nervous system (CNS)
- ❑ Hemiplegia or paraplegia
- ❑ Multiple sclerosis
- ❑ Spinal cord injury

For strabismus, answer the following:

Select if the patient has the following symptoms:

- ❑ Abnormal head turn
- ❑ Asthenopia
- ❑ Diplopia
- ❑ Impairment of peripheral vision due to esotropia

Quantity Limit Requests:

Is there a high risk of significant adverse clinical outcome with medication change or dosage change? ❑ **Yes** ❑ **No**

Is the requested quantity and dose within FDA approved maximum dosing limits or supported by peer-reviewed medical literature, accepted standards of medical practice and/or medical compendia? ❑ **Yes** ❑ **No**

If **yes,** please specify:_____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.